DEPARTMENT OF HEALTH AND HUMAN SERVICES
HEALTH CARE FINANCING ADMINISTRATION

FORM APPROVED
OMB NO. 0938-0193

TRANSMITTAL AND NOTICE OF APPROVAL OF STATE PLAN MATERIAL

FOR: HEALTH CARE FINANCING ADMINISTRATION

1. TRANSMITTAL NUMBER: 02-025

2. STATE: Iowa

3. PROGRAM IDENTIFICATION: TITLE XIX OF THE SOCIAL SECURITY ACT (MEDICAID)

TO: REGIONAL ADMINISTRATOR
HEALTH CARE FINANCING ADMINISTRATION
DEPARTMENT OF HEALTH AND HUMAN SERVICES

4. PROPOSED EFFECTIVE DATE
~~September 12,~~ 2002 July 1, 2002

5. TYPE OF PLAN MATERIAL *(Check One)*:

☐ NEW STATE PLAN ☐ AMENDMENT TO BE CONSIDERED AS NEW PLAN ☒ AMENDMENT

COMPLETE BLOCKS 6 THRU 10 IF THIS IS AN AMENDMENT *(Separate Transmittal for each amendment)*

6. FEDERAL STATUTE/REGULATION CITATION:
42 CFR 447.252

7. FEDERAL BUDGET IMPACT:
a. FFY 02 $ 0
b. FFY 03 $ 0

8. PAGE NUMBER OF THE PLAN SECTION OR ATTACHMENT:
Attachment 4.19-A, pages 2-4, 4a, 4b, 5, 7 & 8, 8a, 10, 10a, 11, 14a, 15, 26-26e, 26e.1

9. PAGE NUMBER OF THE SUPERSEDED PLAN SECTION OR ATTACHMENT *(If Applicable)*:
Attachment 4.19-A, pages 2-4, 5, 7 & 8, 10, 11, 15, 26-26e, 26e.1

10. SUBJECT OF AMENDMENT:
Adds conditions for certain children's hospitals to receive disproportionate share payments from the graduate medical education and disproportionate fund.

11. GOVERNOR'S REVIEW *(Check One)*:

☑ GOVERNOR'S OFFICE REPORTED NO COMMENT
☐ COMMENTS OF GOVERNOR'S OFFICE ENCLOSED
☐ NO REPLY RECEIVED WITHIN 45 DAYS OF SUBMITTAL
☐ OTHER, AS SPECIFIED:

12. SIGNATURE OF STATE AGENCY OFFICIAL:
Jessie K Rasmussen

13. TYPED NAME:
Jessie K. Rasmussen

14. TITLE:
Director

15. DATE SUBMITTED:
Faxed 9/30/02 Mailed 9/30/02

16. RETURN TO:
Director
Department of Human Services
Hoover State Office Building
Des Moines, Iowa 50319-0114

FOR REGIONAL OFFICE USE ONLY

17. DATE RECEIVED:
9-30-02

18. DATE APPROVED:
12-20-02

PLAN APPROVED - ONE COPY ATTACHED

19. EFFECTIVE DATE OF APPROVED MATERIAL:
July 1, 2002

20. SIGNATURE OF REGIONAL OFFICIAL:
Beverly Bowers Smith

21. TYPED NAME:
CHARLENE BROWN

22. TITLE:
Deputy Director, CMSO

23. REMARKS:

FORM HCFA-179 (07-92)

Instructions on Back

Methods and Standards for Establishing Payment Rates for Inpatient Hospital Care

Appropriate, reportable costs are those that meet the Medicare (or HIM-15) principles, are reasonable, and are directly related to patient care. Costs are considered to be reasonable when they do not exceed what a prudent and cost-conscious buyer would pay for a given item or service.

Inclusion in the cost report of costs that are not directly related to patient care or are not in accord with Medicare principles of reimbursement is not appropriate. Examples of administrative and general costs that must be related to patient care to be a reportable cost are:

- Advertising
- Promotional items
- Feasibility studies
- Dues, subscriptions or membership costs
- Contributions made to other organizations
- Home office costs
- Public relations items
- Any patient convenience items
- Management fees for administrative services
- Luxury employee benefits (i.e., country club dues)
- Motor vehicles for patient care
- Reorganization costs

"Blended base amount" means the case-mix-adjusted, hospital-specific operating costs per discharge associated with treating Medicaid patients, plus the statewide average, case-mix-adjusted operating cost per Medicaid discharge, divided by two. This base amount is the value to which add-on payments for inflation and capital costs are added to form a final payment rate. The costs of hospitals receiving reimbursement as critical access hospitals are not used to determine the statewide average, case-mix-adjusted operating cost per Medicaid discharge. For purposes of calculating the disproportionate share rate only, a separate blended base amount is determined for any hospital that qualifies for a disproportionate share payment only as a children's hospital based on a distinct area or areas serving children, using only the case – mix adjusted operating cost per discharge associated with treating Medicaid patients in the distinct area or areas of the hospital where services are provided predominantly to children under 18 years of age.

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"Blended capital costs" means hospital-specific capital costs, plus statewide average capital costs, divided by two. For purposes of calculating the disproportionate share rate only, separate blended capital costs are determined for any hospital that qualifies for a disproportionate share payment only as a children's hospital based on a distinct area or areas serving children, using only the capital costs related to the distinct area or areas of the hospital where services are provided predominantly to children under 18 years of age.

"Capital costs" means an add-on to the blended base amount which shall compensate for Medicaid's portion of capital costs. Capital costs for building, fixtures, and movable equipment are defined in the hospital's base-year cost report, are case-mix adjusted, are adjusted to reflect 80% of allowable costs, and are adjusted to be no greater than one standard deviation off the mean Medicaid blended capital rate. For purposes of calculating the disproportionate share rate only, separate capital costs are determined for any hospital that qualifies for a disproportionate share payment only as a children's hospital based on a distinct area or areas serving children, using only the base year cost report information related to the distinct area or areas of the hospital where services are provided predominantly to children under 18 years of age.

"Case-mix adjusted" means the division of the hospital-specific base amount or other applicable components of the final payment rate by the hospital-specific case-mix index. For purposes of calculating the disproportionate share rate only, a separate case-mix adjustment is determined for any hospital that qualifies for a disproportionate share payment only as a children's hospital based on a distinct area or areas serving children, using the base amount or other applicable component for the distinct area or areas of the hospital where services are provided predominantly to children under 18 years of age.

"Case-mix index" means an arithmetical index used to measure the relative average costliness of cases treated in a hospital as compared to the statewide average. For purposes of calculating the disproportionate share rate only, a separate case-mix index is determined for any hospital that qualifies for a disproportionate share payment only as a children's hospital based on a distinct area or areas serving children, using the average costliness of cases treated in the distinct area or areas of the hospital where services are provided predominantly to children under 18 years of age.

"Children's hospitals" means hospitals with inpatients predominantly under 18 years of age. For purposes of qualifying for disproportionate share payments from the graduate medical education and disproportionate share fund, a children's hospital is defined as a duly licensed hospital that:

- Either provides services predominantly to children under 18 years of age or includes a distinct area or areas that provide services predominantly to children under 18 years of age, and

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- Is a voting member of the National Association of Children's Hospitals and Related Institutions.

"Cost outlier" means a case that has an extraordinarily high cost, so as to be eligible for additional payments above and beyond the initial DRG payment.

"Diagnosis-related group (DRG)" means a group of similar diagnoses based on patient age, organ systems, procedure coding, comorbidity, and complications.

"Direct medical education costs" means costs directly associated with the medical education of interns and residents or other medical education programs, such as a nursing education program or allied health programs, conducted in an inpatient setting, that qualify for payment as medical education costs under the Medicare program. The amount of direct medical education costs is determined from the hospital's base-year cost reports, and is inflated and case-mix-adjusted in determining the direct medical education rate. For purposes of calculating the disproportionate share rate only, separate direct medical education costs are determined for any hospital that qualifies for a disproportionate share payment only as a children's hospital based on a distinct area or areas serving children, using only costs associated with the distinct area or areas in the hospital where services are provided predominantly to children under 18 years of age.

Payment for direct medical education costs is made from the Graduate Medical Education and Disproportionate Share Fund and is not added to the reimbursement for claims.

"Direct medical education rate" means a rate calculated for a hospital reporting medical education costs on the Medicare cost report (HCFA-2552). The rate is calculated using the following formula: Direct medical education costs are multiplied by inflation factors. The result is further divided by the hospital's case-mix index, then is divided by net discharges. For purposes of calculating the disproportionate share rate only, a separate direct medical education rate is determined for any hospital that qualifies for a disproportionate share payment only as a children's hospital based on a distinct area or areas serving children, using the direct medical education costs, case-mix index, and net discharges of the distinct area or areas in the hospital where services are provided predominantly to children under 18 years of age.

"Disproportionate-share payment" means a payment that shall compensate for costs associated with the treatment of a disproportionate share of poor patients. The disproportionate-share payment is made directly from the Graduate Medical Education and Disproportionate Share Fund and is not added to the reimbursement for claims.

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"Disproportionate share percentage" means either (1) the product of 2 ½ percent multiplied by the number of standard deviations by which the hospital's own Medicaid inpatient utilization rate exceeds the statewide mean Medicaid inpatient utilization rate for all hospitals, or (2) 2 ½ percent. A separate disproportionate share percentage is determined for any hospital that qualifies for a disproportionate share payment only as a children's hospital, using the Medicaid inpatient utilization rate for children under 18 years of age at the time of admission in all distinct areas of the hospital where services are provided predominantly to children under 18 years of age.

"Disproportionate share rate" means the sum of the blended base amount, blended capital costs, direct medical education rate, and indirect medical education rate multiplied by the disproportionate share percentage.

"DRG weight" means a number that reflects relative resource consumption as measured by the relative charges by hospitals for cases associated with each DRG. The Iowa-specific DRG weight reflects the relative charge for treating cases classified in a particular DRG compared to the average charge for treating all Medicaid cases in all Iowa hospitals.

"Final payment rate" means the aggregate sum of the two components (the blended base amount and capital costs) that, when added together, form the final dollar value used to calculate each provider's reimbursement amount when multiplied by the DRG weight. These dollar values are displayed on the rate table listing.

"Full DRG transfer" means that a case coded as a transfer to another hospital shall be considered to be a normal claim for recalibration or rebasing purposes if payment is equal to or greater than the full DRG payment.

"Graduate Medical Education and Disproportionate Share Fund" means a reimbursement fund developed as an adjunct reimbursement methodology to directly reimburse qualifying hospitals for the direct and indirect costs associated with the operation of graduate medical education programs and the costs associated with the treatment of a disproportionate share of poor, indigent, nonreimbursed, or nominally reimbursed patients.

"Indirect medical education costs" means costs that are not directly associated with running a medical education program, but are incurred by the facility because of that program (for example, costs of maintaining a more extensive library to serve those educational needs).

The indirect medical education payment is made from the Graduate Medical Education and Disproportionate Share Fund and is not added to the reimbursement for claims.

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"Indirect medical education rate" means a rate calculated as follows:

- The statewide average case-mix adjusted operating cost per Medicaid discharge, divided by two, added to the statewide average capital costs, divided by two.
- The resulting sum is then multiplied by the ratio of the number of full-time equivalent interns and residents serving in a Medicare-approved hospital teaching program divided by the number of beds included in hospital departments served by the interns' and residents' program, and is further multiplied by 1.159.

For purposes of calculating the disproportionate share rate only, a separate indirect medical education rate is determined for any hospital that qualifies for a disproportionate share payment only as a children's hospital based on a distinct area or areas serving children, using the number of full-time equivalent interns and residents and the number of beds in the distinct area or areas in the hospital where services are provided predominantly to children under 18 years of age.

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"Inlier" means a case where the length of stay or cost of treatment falls within the actual calculated length-of-stay criteria, or the cost of treating the patient is within the cost boundaries of a DRG payment.

"Long-stay outlier" means a case that has a length of stay that is greater than the calculated length-of-stay parameters, as defined with the length-of-stay calculations for that DRG.

"Low-income utilization rate" means the ratio of gross billings for all Medicaid, bad debt, and charity care patients, including billings for Medicaid enrollees of managed care organizations and primary care case management organizations, to total billings for all patients. Gross billings do not include cash subsidies received by the hospital for inpatient hospital services except as provided from state or local governments. A separate low-income utilization rate is determined for any hospital qualifying or seeking to qualify for a disproportionate share payment as a children's hospital, using only billings for patients under 18 years of age at the time of admission in the distinct area or areas in the hospital, where services are provided predominantly to children under 18 years of age.

"Medicaid-certified unit" means a hospital-based substance abuse, psychiatric, neonatal, or physical rehabilitation unit that is certified for operation by the Iowa Department of Inspections and Appeals on or after October 1, 1987. Medicaid certification of substance abuse, psychiatric, and rehabilitation units is based on the Medicare reimbursement criteria for these units. A Medicare-certified physical rehabilitation unit or hospital in another state is considered Medicaid-certified.

"Medicaid inpatient utilization rate" means the number of total Medicaid days, including days for Medicaid enrollees of managed care organizations and primary care case management organizations, both in-state and out-of-state, and Iowa state indigent patient days divided by the number of total inpatient days for both in-state and out-of-state recipients. Children's hospitals, including hospitals qualifying for disproportionate share as a children's hospital, receive twice the percentage of inpatient hospital days attributable to Medicaid patients. A separate Medicaid inpatient utilization rate is determined for any hospital qualifying or seeking to qualify for a disproportionate share payment as a children's hospital, using only Medicaid days, Iowa state indigent patient days, and total inpatient days attributable to patients under 18 years of age at the time of admission in all distinct areas of the hospital where services are provided predominantly to children under 18 years of age.

"Neonatal intensive care unit" means a neonatal unit designated level II or level III unit using standards set forth in Section 19, Payment for Medicaid-Certified Special Units.

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3. Definition of Allowable Costs

Allowable costs are those defined as allowable in 42 CFR, Part 413, except as specifically excluded or restricted in the state plan.

Costs are allowable only to the extent that they relate to patient care; are reasonable, ordinary and necessary; and are not in excess of what a prudent and cost-conscious buyer would pay for the given service or item. Only those costs are considered in calculating the Medicaid inpatient reimbursable cost per discharge for the purpose of this plan.

4. Explanation of the Cost and Rate Calculations

The base-year allowable costs used for determining the hospital-specific cost per discharge and the statewide average cost per discharge can be determined by using the individual hospital's 2001 Medicare Cost Report (HCFA-2552), Worksheets D-1 and D-4, as submitted to the state.

The total number of Medicaid discharges can be determined from documents labeled PPS-1 and PPS-2, Worksheet S-3 in the report or the MMIS claims documentation system.

a. Calculation of Hospital-Specific and Statewide Net Medicaid Discharges

The total number of Medicaid discharges is determined from the number reported in the cost report or the MMIS claims documentation system. Subtracted from this total number of discharges for each hospital are discharges that have been paid as transfers or short-stay outliers.

This number is known as the net hospital-specific number of discharges. To arrive at the statewide net number of discharges, all net hospital-specific numbers of discharges are summed. For purposes of calculating the disproportionate share rate only, separate discharges are determined for any hospital that qualifies for a disproportionate share payment only as a children's hospital based on a distinct area or areas serving children, using the costs, charges, expenditures, payments, discharges, transfers, and outliers attributable to the distinct area or areas in the hospital where services are provided predominantly to children under 18 years of age.

b. Calculation of the Hospital-Specific Case-Mix-Adjusted Average Cost Per Discharge

As determined from the 2001 base-year cost report, the hospital-specific case-mix adjusted average cost per discharge is calculated by starting from:

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The **lower** of total Medicaid costs **or** covered reasonable charges for each Iowa hospital (LOCOC) less 20% of capital expenses
- The remaining 80% of actual costs reported for capital expenditures
- The actual costs reported for direct medical education
- Calculated payments made for non-full DRG transfers
- Calculated payments made for outliers
- Payment made for physical rehabilitation (if included)

= **Net allowable base costs or charges**

The net allowable base costs or charges amount is then inflated, case-mix-adjusted and divided by the net number of hospital-specific Medicaid discharges to obtain the hospital-specific case-mix-adjusted average cost per discharge, as shown:

Net allowable base costs or charges
× Hospital inflation update factor
= Inflated net allowable base cost
÷ Hospital-specific case-mix index
= Inflated, case-mix-adjusted net allowable base costs or charges
÷ Net hospital-specific Medicaid discharges (less non-full DRG transfers and short stay outliers)
= Hospital-specific case-mix-adjusted average cost per discharge.

For purposes of calculating the disproportionate share rate only, a separate hospital-specific case-mix adjusted average cost per discharge is calculated for any hospital that qualifies for a disproportionate share payment only as a children's hospital based on a distinct area or areas serving children, using the costs, charges, expenditures, payments, discharges, transfers, and outliers attributable to the distinct area or areas in the hospital where services are provided predominantly to children under 18 years of age.

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c. Calculation of the Statewide Average Case-Mix-Adjusted Cost per Discharge

The statewide average case-mix-adjusted cost per discharge is calculated from:

The **LOCOC figures** for each Iowa hospital, except those receiving reimbursement as critical access hospitals, less 20% of actual capital costs as reported

– The remaining 80% of hospital-specific capital costs

– Hospital-specific direct medical education costs

– All hospital-specific payments for transfers

– All hospital-specific payment for outliers

– All hospital-specific payments for physical rehabilitation (if included in above)

– All hospital-specific payments for indirect medical education

= Hospital-specific net base cost for statewide average

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The capital component is calculated by taking the sum of the routine and ancillary capital-related costs from the submitted Medicaid cost report, multiplying by 80%, dividing by the hospital-specific case-mix index and then dividing by the net number of Medicaid discharges for that hospital.

Hospitals whose blended capital add-on exceeds one standard deviation from the mean Medicaid capital rate will be subject to a reduction in their capital add-on to equal the greatest amount of the first standard deviation.

The sum of the hospital-specific routine and ancillary capital costs multiplied by 0.8
÷ Hospital-specific case-mix index
= Case-mix-adjusted capital cost component
÷ Net number of hospital-specific Medicaid discharges
= **Case-mix-adjusted hospital-specific capital cost per discharge**

For purposes of calculating the disproportionate share rate only, a separate case-mix adjusted hospital-specific capital cost per discharge is calculated for any hospital that qualifies for a disproportionate share payment only as a children's hospital based on a distinct area or areas serving children, using the discharges and routine and ancillary capital costs multiplied by 0.8, attributable to the distinct area or areas in the hospital where services are provided predominantly to children under 18 years of age.

The statewide average capital cost per discharge is determined by adding together all hospital-specific case-mix-adjusted capital costs for all Iowa hospitals. This total is divided by the total statewide number of net Medicaid discharges. The total number of net discharges is calculated by adding together all the hospital-specific net discharge figures for all Iowa Medicaid discharges. Net discharges are defined within Section 4, paragraph (a).

+ Hospital 1 case-mix-adjusted capital costs
+ Hospital 2 case-mix-adjusted capital costs
+ Hospital 3 case-mix-adjusted capital costs
+ Hospital N case-mix-adjusted capital costs
= Statewide total case-mix-adjusted capital costs
÷ Statewide total number of net Medicaid discharge
= **Statewide average case-mix-adjusted capital cost per discharge**

The blended capital cost component is determined by adding together the hospital-specific case-mix-adjusted capital cost per discharge and the statewide average case-mix-adjusted capital cost per discharge and dividing by 2. This blended capital rate component is added to the final blended base rate.